from time immemorial to the present; he has gone into detail and has told us what the old school taught us, but he has not told us what we may expect, or in other words the horoscope of the future. This would be a hard thing to tell, and I look upon Dr. Krotoszyner as an able practitioner in that line, because the opportunities are so great in urology and genito-urinary work that no human mind at the present can foretell what the future will bring forth if we measure it by what has been done in the last few years. New instruments daily are being made and daily we read of new methods in the journals; the old books have passed as the old instruments have; they are curiosities and in time will be placed in the curiosity shop, as the instruments that were used by Babylonians. We are looking forward to the future; every man is weighed by his capacity to go into deeper work, and I believe the urologist of to-day, as recognized, will not be the urologist of tomorrow. This branch of medicine opens up a field to every young man. I believe that we are going to be able to transplant successfully kidney tissue so as to overcome the lack of functional capacity, that we often hesitate in the present time in the removal of a kidney for fear that the other will not be able to functionate properly. We are borderline specialists, we are dependent upon the neurologists and the gynecologists, but the time will come when we have so perfected ourselves that gynecology will be a misnomer, as our mistakes are often those which make the gynecologist.

Dr. Chester J. Teass: I did not come here this evening with the intention of discussing any paper, but since you have done me the honor to call upon me, I would like to say a few words on urology in relation to the general practitioner, as I am no specialist, having done general work most of the time for the past thirteen years. I think there is no question of the vast importance of the subject, and that every man in the general practice of medicine, particularly those doing surgical work on the kidneys, should familiarize himself with examining the interior of the bladder and catheterizing the ureters, for only after such knowledge as is thereby gained, is any operative procedure on the kidneys at all warranted.

I have in mind a recent case that came to Cooper Medical College in the service of Dr. Somers, in which one kidney had been removed a few months since by one of the well known surgeons of the town, and upon examination we find the remaining kidney badly diseased, giving rise to general symptoms; that means it will be a matter of time before the patient reaches a fatal termination. There is no doubt but that this kidney was diseased at the time of the removal of its mate, which should have been determined by a careful ureteral catheterization, and thus have avoided an unnecessary operation, which is always to the discredit of general surgery. Even though the kidney that was removed was badly diseased, in all probability some part of it was functionating, which would have been that much of an aid to the remaining diseased kidney.

Most of the cases of to-day are done by the so-called water method, and we hear nothing of the dry or air inflation method, but while I was on a recent visit to the East and Europe, I stopped at Baltimore to visit Dr. Howard Kelly, and one morning he took me into a private room, where he had a woman on the table, and exclaimed, "I wish to show you how dramatic this procedure can be made." Suiting the action to the word he placed a cannula into the urethra allowing the air to rush in and distend the bladder; he now rapidly located the orifices of both ureters, stepped backward four feet from the patient to where he had the catheter lying on a table, picked up a catheter between his thumb, middle and index fingers, took a quick step towards the patient, and quickly and most skillfully shot the catheter up to the kidney pelvis, repeated the operation on the opposite side. The whole procedure did not consume much over a minute of time after the patient's bladder had become properly inflated with air. But as we all cannot be Howard Kellys in this field of work, we must adopt any method that we can be the most successful with.

Dr. M. Krotoszyner: The address just read was intended for the medical profession in general. Therefore, I purposely omitted to dwell upon the advances made of late in the perfection of special urological instruments like urethroscopes, instruments for intravesical therapy, etc. There is no doubt that Goldschmidt's water-urethroscope marks a decided step forward towards making endoscopy of the posterior urethra an exact diagnostic method and I am glad that this point was brought out in the discussion. As regards the reading of the horoscope for the future of urology I am convinced that that part of my paper was sufficiently exhaustive. I did not wish to enter into any speculations upon the future development of our specialty. I have outlined the possibilities of urology as a border-line specialty in relation to general medicine and its importance for teaching purposes. If these prophecies will come true in San Francisco and on the Pacific Coast during our years of activity I am sure that all of us will have good cause to be well satisfied. It is to be hoped that the proceedings of this Section will be of definite value to the general practitioner and incidentally arouse in him a continued interest for scientific urology.

Epididymotomy in Gonorrheal Epididymitis.

By LOUIS GROSS, M. D., San Francisco.

While the general recognition of the value of epididymotomy in the treatment of gonorrheal inflammation of the epididymis awaits the education of a conservative medical fraternity, it is conceded by all those performing the operation that the results are uniformly successful.

Two years ago the writer presented a paper on the same subject before the San Francisco branch of the American Urological Association, wherein ten cases were reported, and since that publication, the writer has had no cause to alter his previous ideas of its value, or the technic pursued, but, on the contrary, feels that it is an operation that should be undertaken more often and predicts that the majority of cases will, in the future, be surgically treated.

History. Puncture of the epididymis and tunica albuginea have been practiced many years; Pirogoff in 1852 punctured the testicle for orchitis, at that time the writers making no distinction between orchitis and epididymitis. In 1863 H. Smith incised the tunica albuginea in 1000 cases, resorting to it because of an erroneous diagnosis of abscess of the testicle; Spencer Watson in 1867 punctured the tunica vaginalis in 20 cases, particularly when effusion was present, this showing that puncture of the epididymis is an old method but one that had never become very popular. In Germany its revival began when Baerman in 1903 described 28 cases; Schindler also helped to resurrect this procedure. In this country, Belfield in April, 1905, published an article on "Pus Tubes in the Male and Their Treatment," advocating the operation of drainage of the epididymis, and in January, 1906, Bazet, in an article on "Epididymitis Based on Sixty-Five Cases," advised epididymotomy in all cases. In October, 1906, Hagner, working independently, introduced his method by reporting a series of six cases.

Operative Procedures. The following are the different methods of procedure: Belfield follows the plan of opening the canal of the vas and injecting the proximal duct with a silver compound.

Bazet's technic is as follows: He chooses the ligamentum scrotale for the incision, seizes firmly the swollen indurated nodule of the globus minor of the epididymis in the left hand and an incision one inch long is made downward into the cavity of the epididymis. He then exposes the nodules, relieves the

tension and punctures the nodules, if pus is present, and stitches the walls of the epididymis to the skin. He packs the wound with gauze impregnated with 1 to 10 ichthyol and glycerin and supports the organ.

In Hagner's operation, an incision is made 6 to 10 cm. in length at the juncture of the swollen epididymis and testicle through the scrotum down to the tunica vaginalis, which is opened at the juncture of the epididymis and testicle. After the serous membrane is opened all the fluid is vacuated. The epididymis is then examined and multiple punctures made through its fibrous covering, especially over those portions where the enlargement and thickening is greatest. The knife is carried deep enough to penetrate the thickened fibrous capsule and enter the infiltrated connective tissue. If pus is seen to escape from any of the punctures, the opening is enlarged and a small probe inserted in the direction from which the pus flows, and with a fine-pointed syringe, the cavity is washed with a 1 to 1000 solution of corrosive sublimate, followed by a normal salt solution. A cigarette drain is used. A continuous catgut suture closes the tunica vaginalis and a lockstitch horsehair suture the scrotal skin. Moist bichloride of mercury dressings and a scrotal support to the testicle complete the process.

Dind and Metraux's method of procedure is to "pull the scrotum over the pubes, holding the lateral surface of the epididymis between the thumb and index finger of the left hand and incising the skin thus made tense. The incision is started over the tail of the organ and is prolonged according to indications, differing in each case, rarely extending to the head. The incision, made layer by layer, finally reaches the purulent focus, which is wiped out with gauze or scraped with a dull curette."

Schindler introduces his trocar for a distance of about 4 cm., puncturing from the tail upward or wherever the presence of an abscess may be felt, while Bruck, at the suggestion of Neisser, has adopted a simple incision into the tunica propria, without entering the epididymis itself.

The Germans, as a rule, use simple puncture, although there are some like Boross who incise. Ernst punctures the nodules with a Luer syringe and penetrates 1 to 2 cm. deep into the substance of the globus minor and aspirates, and he claims that one puncture, as a rule, is all that is necessary; although he has been forced to perform the same process a second or even a third time.

The writer still adheres to Bazet's technic and finds it most satisfactory. An incision is made in the globus minor sufficiently deep to penetrate its canal; a probe is introduced up the body of the epididymis for an inch to an inch and a half, and the walls of the globus minor sutured to the skin. It is rarely necessary to open the tunica vaginalis since the serum present is rapidly absorbed unless a large amount is present.

Anesthesia. As a rule, the Germans use neither general nor local anesthesia and claim there is only a "minimum of pain if performed properly"; yet, notwithstanding this statement, the writer would hesitate to operate without an anesthetic.

The American surgeons use general anesthesia and the writer has used ether, nitrous oxide and local anesthesia, but would not advise local as one cannot obtain the necessary freedom from pain. Ether or nitrous oxide should be used, with preference for the latter.

The following cases are of interest: Case 1. J. P. C., age 20, clerk, single. Consulted me April 20, 1910. The last three years he has had gonorrhea. Does not know whether this is a new or latent infection. He has been treated by an Oakland physician for the last fourteen days for epididymitis, with ichthyol ointment and rest, but is still suffering. There is some frequency of urination, diurnally, no tenesmus, no hematuria. On palpation, the left epididymis was found enlarged and painful. Four glass tests show cloudiness in all glasses. Discharge profuse and loaded with gonococci. Prostate sensitive to touch, enlarged and expressed secretion contained numerous colonies of gonococci and leukocytes. Epididymotomy was advised and Dr. Chas. Pauson was called to administer nitrous oxide anesthesia in my office. After resting an hour, the patient took street car from office to his home, returning to the office next day and reporting himself very comfortable. Vas deferens much reduced in size. April 26th, 6 days later, all treatment of epididymis discontinued.

This case is recorded for the following reasons: Simplicity of operation, the rapidity of relief of pain and the brevity of duration of illness.

Case 2. H. C., 40 years old, married, secretary. Consulted me March 15, 1911, for an acute gonorrhea, involving anterior and posterior urethra and prostate. Refused to go to bed and was treated until May 3, 1911, when he was forced to rest on account of a left side epididymitis. Operation refused. In bed 12 days. Is better (May 30, 1911) but still noticed some slight aching in epididymis, while the urines are still cloudy.

This case is reported to contrast the time in convalescence in the operated and unoperated case, and further, had this case been operated, I could unhesitatingly say that by now the prostate would have resumed a normal state.

Case 3. G. B. P., age 25, single, jeweler. Jan. 17, 1910, no luetic history, gonorrhea and chancroid five years ago. Present illness began two days ago. Diagnosis: Acute anterior and subacute posterior gonorrhea. Ten days later, on Jan. 27, 1910, noticed blood at end of urination. Jan. 28th, urination still bloody, sent to bed. Feb. 4, 1910, left epididymitis; operation refused. Remained at rest in Mt. Zion Hospital, light diet, antiphlogistic treatment, temperature varied from 99° to 102.8°. On the 14th day temperature highest and on 15th day of rest (Feb. 19) was operated and left epididymis opened and drained. On Feb. 25th, 6 days after operation, was discharged from hospital. Twenty days later (Mch. 17, 1910) right epididymitis. Operated upon and removed to his home the following day. On Sept. 19, 1910, few motile spermatozoa found in semen. I may add that the prostate was much reduced in size after each operation.

This history is presented to show that an epididymotomy does not cause sterility.

With the 10 cases reported previously, the writer now has 25 cases, the results of which are very gratifying, and this operation must have a definite place in surgery.

Hagner operates in only 10%, while Bazet in all of his cases. Baerman advocates early puncture, even in the presence of extremely acute symptoms. Schindler recommends that every cast of epididymitis accompanied by fever should be treated by puncture. Houssian says it should be done in every case with severe inflammation, in chronic cases and in cases with recurrences.

The writer is more radical now than he was a few years ago, and although he does not advocate it in every case he feels it should be done in the majority of patients suffering from epididymitis. When you consider not only the reduced number of days of confinement to bed (Heinze claims in his series of cases, with operation there were 299 days, while without operation there were 529 days of confinement to bed, a gain of 43%); when you consider the rapidity of convalescence in its favor, for the prostate and seminal vesicles are restored much more quickly after operation; when you consider the rapidity of relief of pain and the disappearance of fever, in fact, it is an operation favorable from all points of view and of incontestable superiority, therefore everything considered, the writer feels it should convince the skeptical as well as the conservative practitioner.

BIBLIOGRAPHY.

Baerman—Deutsch. Med. Woch., 1903, No. 40.
Bazet—Amer. J. Urology, May, 1906.
Belfield—Journal Amer. Med. Assn., April 22, 1905.

Boross—Urolog. Szemle. 126.
Bruck, C.—Med. Klinik., May 22, 1910.
Dind & Metraux—Annal. d. Mal. d. Orig. G. U. No. 5, 1908.
Ernst—Berl. Klin. Woch., No. 10-11.
Gross, Louis—Amer. J. Urology, June, 1909.
Hagner—Med. Record, Oct. 13, 1906.
Hagner—Annals Surg., Dec., 1908.
Hagner—Med. Rec., Dec., 1909.
Heinze—Dermatol. Ztschr., 1908, XV, 141-46.
Houssian—Annal d. Mal. d. org. G. U., Vol. 1, No. 1.
Morton—Long Island Med. J., Mch., 1910.
Schindler—Deutsche Med. Woch., XXXII, No. 51.
Smith—Lancet, 1864, Vol. II, p. 149.
Smith, G. C.—Boston M. &. S. Jour., Feb. 2, 1911.

Discussion.

Dr. J. C. Spencer: I believe Dr. Krotoszyner was present at a little meeting in Dr. Chismore's office when Dr. Bazet read a paper upon epididymotomy. My attention was called to this operation on that occasion for the first time. I must admit that it did not appeal to me very strongly, the operation being as has been fully described to you by the reader of the paper and my attitude to it was a conservative one. I have tried to keep myself au courant with the progress recorded for the relief of epididymitis and as time has gone on I have found that the subject of vaccines has assumed greater and greater significance. My experience with epididymitis has practically been summed up in a paper which I read in this room several months ago and the standpoint I took then is the one I see no reason to change. I use the autogenous vaccines, supplemented with the use of saturated solution of sulphate of magnesia, applied constantly to the scrotum covering the inflamed epididymis and testicle, and when I see, as I have in a limited number of cases, treated with vaccines, the symptoms all resolve in 48 hours at the outside, I am not tempted to take the knife and make an incision into the inflamed epididymis. I have witnessed the sudden drop of the temperature and relief of agonizing pain, and to make an incision in this region, which is undoubtedly a region difficult to keep clean in a surgical sense, is hardly to be compared with the prompt and comparatively simple method of injecting with autogenous vaccines. According to the paper just read, the minimum period of convalescence of these cases is about 6 days and this can hardly be compared even with the simplicity of acupuncture, which, with aspiration, relieves the tension and so relieves the symptoms of the lesion and is far simpler than the incision. It is for this reason that I cannot see my way clear to subjecting a patient to a serious surgical operation and making quite a formidable affair of what need not be more than an injection of the vaccine.

Dr. Geo. Lee Eaton: In discussing the problem of epididymotomy the great question to consider is: are we going to produce sterility, if the testicle be left alone for Dr. Spencer to treat by his method and possibly have sterility, then as a matter of fact if Dr. Gross can produce in a sterile subject by epididymotomy, spermatozoa in the secretions, then I believe the question is on the side in favor of Dr. Gross. But let us look at it in a scientific way; if you have pus tubes in a female after opening the belly and you find the slightest inflammatory process in the tubes due to gonococcus, the tubes and ovaries are generally removed; if that be right in the female, well then, let us take this argument for the male. If we can produce a virile subject by epididymotomy let us use the knife. The question of the day is, that sterility is being predominantly produced by infection of gonorrhea, both in the female and male, and it is our scientific hopes to bring them back to the normal state as near as possible. It would appear that Dr. Gross depends entirely upon the surgical method. It would seem wise that if the doctor at the time upon opening the epididymis and the finding of pus, if he would go a step further and make a culture of that pus, grow the bacteria, make a mixed vaccine and inject it into the individual. The doctor has no guaranty that the prostatic follicles and vesicles are not infected with some other micro-organisms than the gonococcus that may lend a helping hand to the production of the epididymitis and by carrying his method a little further he would ultimately eradicate all of the micro-organisms that go to produce the epididymitis. There still remains a question in the minds of the genito-urinary specialists whether the epididymitis is solely produced by the gonococcus. I believe that it is the opinion of the bacteriologists, urologists and genito-urinary men of to-day that it is dependent entirely upon mixed infection; so that wherever you have epididymitis the question of vaccines is well taken by Dr. Spencer, but if Dr. Gross would only go further and use autogenous vaccines and continue to inject these vaccines I believe that the doctor would be more pleased with his results.

Dr. Harry Spiro: As a general practitioner I believe that it is not always necessary to remove both tubes and ovaries of a female infected with gonorrhea; we can often save both of these organs; even if we do remove the female organs that is no reason why we should do the same thing in the case of a man. As to the question of sterility, I do believe there are many cases of men to-day who have healthy children and who have never had an epididymotomy performed upon them, even though they had an epididymitis.

Dr. Victor C. Vecki: Some years ago I was in the same boat that Dr. Spencer is in to-day, when I listened to Dr. Bazet's paper, and looking from the standpoint that I would not like to inflict upon any of my fellow-creatures anything that I would not want done to myself, I thought it was better to keep on with the old lotions, etc., but I must confess that I have been thoroughly and entirely converted. During the last year every case of epididymitis that came under my hands was operated upon and I am glad to say so because the results were always most beautiful,—almost charming. The first case I operated upon was one that I was at a loss to know what to do because the man did not get well of the inflammation and finally I took him to the hospital and with Dr. Gross's able help, operated upon the epididymis and the result was a most remarkable one. It was a very instructive case because the man formerly had a left sided epididymitis and such a hardening and induration left there that I am positive his left testicle did not functionate any more. He now has very lively spermatozoa; I am sure that had I waited the right testicle would have become as the left was, and the man would have been sterile, which he is not. The last case I operated on was in the French Hospital a few weeks ago. The man had been suffering from a chronic gonorrhea for quite a while and no practitioners or specialists had been able to help him. He was operated on and he now had no discharge, the prostate gland took on its normal size, the testicle reduced in size and the pain was almost immediately relieved and he is now able to do his work. We must not attach too much importance to the finding of spermatozoa a short time after the operation, for it is possible that they did not come from the testicles because it may have been stored in the seminal vesicles for quite a while and not be a new production, so it will take more than a few weeks to really determine whether there is sterility or not.

Dr. Louis Gross: I regret Dr. Spencer has not performed this operation, for had he done so he would have been pleased with the results. In these cases I had used both autogenous and stock vaccines and have obtained no results. I wish to impress the members that this is not an epididymectomy but an epididymotomy, we are only cutting into the epididymis, not removing it. The statistics of cases of double sided epididymitis show sterility, yet in this case of double epididymotomy reported to-night there is no sterility. I do not advise operation in all cases, only the special ones. It is certainly remarkable to

see how quickly the prostate and seminal vesicles resume their normal state after this operation, in contrast to the cases without operation.

Report of Cases by Dr. Krotoszyner.

Dr. Krotoszyner reported two cases of kidney colic in connection with herpes zoster. In both cases a typical herpes zoster was observed in Head's peripheral hyper-algetic zone of the kidney. In one case the attacks of kidney colic had been caused by a left-sided hydro-nephrotic sac due to obstruction of the ureter by means of a small calculus. In the other case the attacks were caused by a unilateral nephritis and peri-nephritis in a right-sided stone kidney. In both cases the removal of the diseased kidney was followed by recovery.

These observations will later be published in extenso.

Demonstration of Specimen from a Case of Liver Abscess.

By LEO MUNTER, M. D.

Mr. H. H. was first seen by me on July 12th, 1909. At that time he complained of weakness, headache and of perspiring freely, particularly at night, with occasional chills, this having lasted about one week. He also had a slight cough, some little sputum which had a bad taste, and on coughing there was pain in the right chest. He was 53, of good habits, his previous history uneventful, and except for one brother dying of gallstones, the family history was negative.

From July 12 to August 31, the patient was kept in the hospital. During this time he ran an irregular, intermittent temperature, at times up to 106.6 (rectal), with a pulse practically never over 120, and usually of about normal frequency. Respirations were always normal.

Examination of patient showed but slight and inconstant rigidity of the upper part of the right rectus, which made us think of the possibility of trouble in the liver, such as an abscess, or of some renal or perirenal suppuration. Blood examinations showed leukocytes ranging from 14,000 to 30,000 with polys about 88%. Malarial plasmodia repeatedly looked for in fresh specimens at times of chills as well as in stained specimens were never seen. Reports of cases of dysentery being common at this period, the patient's stools were frequently examined but ameba never found. Widals were absolutely negative. The urine showed large amounts of albumin and casts, warranting at least the diagnosis of a parenchymatous nephritis, and from July 19th to 24th, a marked bacteriuria was present, associated with a pyuria, so that a pyelitis was suspected. On the 9th of August the ureters were catheterized, with negative report.

About this time the patient began to improve, and he attributed this to the presence of a loose cough with a slight purulent expectoration. The patient left the hospital feeling practically well, but he still retained his albuminuria. The most probable diagnosis so far as I could see, was that of a liver abscess, which opinion had been expressed by Dr. Bine, who saw him repeatedly with me while in the hospital. On the other hand, Dr. Kerr, who saw him but once, thought a malarial infection most probable, and quinine was therefore administered, after which no more chills or high fever occurred.

The patient remained well until April 8th, when he began to have about the same symptoms as with his first attack, with the addition of pain in the right infraclavicular region, increased on deep inspiration. He entered the hospital on the 11th, from which time Dr. Bine and I saw him together. Examination again showed a rigidity of the right rectus, with tenderness in this region; but repeated examinations, at times in the hot bath, revealed no definite mass. The chest was negative. Leukocytes, 15,000. Temperature to 102.6 rectal, and was irregularly intermittent. There were no chills. Pulse and respiration were normal. Widal negative. With his illness of 1909 ever before us, we again suspected a liver abscess but could in no way clinch the diagnosis.

On April 17th signs of effusion in the right pleura led to an exploratory puncture. A few cc. of clear fluid were withdrawn. Cultures and smears were negative.

By the 22nd the signs of effusion were very marked, and the patient's condition worse, so that an empyema was diagnosed, but punctures made in the 7th and 8th spaces withdrew about 300 cc. of clear fluid, these aspirations, as well as the one of the 17th, being interrupted by the appearance of bright red blood.

By the 26th the general condition became very much worse; pulse jumped up and respirations became very rapid. On the 27th exploratory punctures were again made, the 3rd attempt being followed by a spurt of pus; 1500 cc. were aspirated; smears showed numerous streptococci. Two hours later, under local anesthesia, rib resection was performed. The diaphragm was found pushed up, and though the pus cavity seemed well walled off, a needle was inserted into the liver, but without finding pus. The patient stood the operation nicely, but in spite of stimulation, grew progressively worse. On the 28th, not satisrfied that all foci had been found, for the signs of effusion were still present anteriorly and less so posteriorly, needles were again inserted through the wound into the liver and also into the pleural cavity and the liver area anteriorly, but without finding pus. Death occurred at 9:15 p. m.

Postmortem performed by Dr. Dickson.

The following extract from the postmortem notes describe the essential lesions. On removal of sternum, large abscess cavity is exposed to right of mid-line. Left lung is small, crowded to left, has practically no fluid in pleural sac, but is bound down by fairly dense adhesions, particularly the lower lobe, especially posteriorly. On passing the hand around the right lung, breaking down the fibrinous adhesions in right pleural sac, a moderate amount of a dirty somewhat blood-stained pus escapes. The adhesions are all recent character except a dense band in axillary line about level fifth rib. The incision opened into a partially walled off cavity, walls of which were covered with fibrino-purulent exudate. On removing the lung, perforation in diaphragm found at summit of the arch on right side. Lung is small, almost completely collapsed, lower lobe alone containing small amount of air. Spleen about twice normal size.

Liver fairly adherent to diaphragm around the region of perforation. Liver very large, soft, somewhat pale. In right lobe, at extremity of dome, is large abscess cavity, about 5 cm. in diameter, walls of which are lined with shaggy fibrino-purulent material. This abscess opened into right pleural cavity through perforation in diaphragm. On the posterior surface of left lobe is large soft and fluctuating mass about size of small orange; on section large amount greenish pus escapes; the walls are lined with smooth, dense fibrous tissue. On cutting from before backwards through the upper abscess a number of smaller abscesses varying in size, up to 1 cm. in diameter, are found in the liver tissue behind it. There is at least 1½ inch of normal looking tissue between these abscesses and the one on the posterior surface of liver.

SAN DIEGO COUNTY.

A free clinic and dispensary has been opened in San Diego for the treatment of general medical and surgical cases. The clinic is to be known as the Talent Workers' Clinic, and is conducted jointly by the San Diego County Medical Society and a charitable organization known as the Talent Workers, whose ultimate aim is the establishment of a large general hospital for both charity and pay patients.

Several rooms have been fitted up in the same building as is occupied by the Anti-tuberculosis